

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  385141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/06/2025
NAME OF PROVIDER OR SUPPLIER  Mt. Tabor Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  6040 SE Belmont Street Portland, OR 97215	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on interview and record review it was determined the facility failed to respect resident rights for 1 of 1 sampled resident (#8) reviewed for personal property. This placed residents at risk for diminished quality of life. Findings include:</p> <p>Resident 8 was admitted to the facility in 4/2016 with diagnoses including depression.</p> <p>An 8/31/24 Progress Note revealed the facility called the police related to reports of Resident 8 watching illegal pornography on her/his phone. The police spoke with Resident 8 and directed facility staff to take Resident 8's phone away and not give the phone back. The nurse took Resident 8's phone and locked it in the Resident Care Manager's office.</p> <p>A 5/1/25 Significant Change MDS indicated Resident 8 was cognitively intact.</p> <p>On 6/2/25 at 9:13 AM Resident 8 stated the facility took her/his phone in 9/2024 due to an accusation of watching pornographic videos on her/his phone. Resident 8 stated she/he wanted her/his phone back.</p> <p>On 6/3/25 at 2:10 PM Staff 20 (LPN) stated on 8/31/24 Resident 8 was observed watching illegal pornography and Staff 20 called the police. Staff 20 stated the police came to the facility and told her to take Resident 8's phone away and not to give it back to Resident 8.</p> <p>On 6/4/25 at 9:51 AM Staff 1 (Administrator) stated there was no formal investigation completed after Resident 8's phone was taken on 8/31/24. Staff 1 stated the police instructed Staff 20 to take Resident 8's phone on 8/31/24. Staff 1 stated facility staff assisted Resident 8 with the internet as requested and Resident 8 had access to a cordless phone to make phone call.</p> <p>On 6/5/25 at 11:39 AM Staff 3 (LPN Care Manager) stated Resident 8 had a history of viewing illegal pornography, so her/his phone was locked in the medication room. Staff 3 stated Resident 8 had access to the cordless phone, she assisted Resident 8 with looking up things on the internet, and Resident 8's friend assisted Resident 8 obtain a flip phone without internet access.</p> <p>On 6/5/25 at 12:06 PM Staff 14 (Social Service Director) stated Resident 8's phone was taken in the past, but was given back to Resident 8 because it was her/his right to have her/his phone. Staff 14 was unaware Resident 8 did not have her/his phone.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/5/25 at 12:13 PM Staff 2 (DNS) stated Resident 8's phone was lock up in the medication room on 8/31/25 due to Resident 8 watching illegal pornographic videos on her/his phone.</p> <p>On 6/6/25 at 8:36 AM Staff 1 acknowledged it was Resident 8's right to have her/his phone.</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>Based on observation, interview and record review it was determined the facility failed to ensure residents were assessed for safe self-administration of medications for 1 of 1 sampled resident (#44) reviewed for self-administration of medications. This placed residents at risk for unsafe medication administration and adverse medication side effects. Findings include:</p> <p>The facility's Self-Administration of Drugs policy, dated 5/2010, revealed the following:</p> <ul style="list-style-type: none"> <li>- Residents who wished to self-administer medications may do so if it was determined they were capable of doing so.</li> <li>-Medications must be stored in a safe and secure place, not accessible by other residents.</li> </ul> <p>Resident 44 was admitted to the facility in 1/2025 with diagnoses including a stroke with hemiparesis and hemiplegia (weakness or complete paralysis or loss of function on one side of the body) affecting the left dominant side.</p> <p>During observations on 6/2/25 at 12:13 PM, four round pills and one capsule was observed, unsecured, on top of the resident's nightstand and on 6/3/25 at 8:24 AM, one round pill was observed, unsecured, on top of the same nightstand.</p> <p>Resident 44's 4/22/25 Quarterly MDS indicated the resident had no significant cognitive impairment.</p> <p>Resident 44's 4/2025, 5/2025 and 6/2025 MAR indicated on 4/26/25, the resident was approved by her/his PCP to have Tylenol and Melatonin at the bedside to self administer, every shift, for pain and sleep.</p> <p>A review of Resident 44's health record revealed no self-administration of medication assessment was completed to determine the resident's ability to safely self-administer Tylenol or Melatonin.</p> <p>On 6/2/25 at 12:13 PM and 6/3/25 at 8:24 AM and 11:22 AM, Resident 44 stated, since 4/2025, it was ok for her/him to have medications at the bedside and she/he did not have a lockbox to secure and store the medications. Resident 44 stated every evening shift she/he asked for two Tylenol and two Melatonin pills which were administered to her/him, and if she/he did not need them she/he saved them to take later. On 6/2/25 at 12:13 PM, Resident 44 confirmed there were four round pills and one capsule on top of her/his bedside nightstand and on 6/3/25 at 8:24 AM, the resident confirmed one round pill remained on her/his bedside nightstand because she/he had taken the other pills.</p> <p>On 6/3/25 at 11:09 AM, Staff 4 (CMA) stated Resident 44 was able to have Tylenol and Melatonin at her/his bedside since 4/2025.</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/3/25 at 12:05 PM and 6/5/25 at 9:17 AM, Staff 3 (LPN Care Manager) stated in the morning on 6/3/25, Resident 44 came to me and reported she/he kept medications at her/his bedside. Staff 3 stated she was unaware the resident kept medications at the bedside. Staff 3 stated in 4/2025, Staff 5 (LPN) obtained a physician order which allowed Resident 44 to have Tylenol and Melatonin at her/his bedside but the nurse did not follow the facility process thus Resident 44 did not have a self-administration of medication assessment completed and no lockbox was given to the resident. Staff 3 stated Resident 44 should not have had medications at her/his bedside.</p> <p>On 6/4/25 at 9:49 AM, Staff 5 stated on 4/26/25, she obtained a physician order which allowed Resident 44 to have her/his Tylenol and Melatonin at her/his bedside. Staff 5 stated she was unsure why Resident 44 did not receive a self-administration of medication assessment until 6/3/25.</p> <p>On 6/5/25 at 1:02 PM, Staff 2 (DNS) confirmed, in 4/2025, nursing staff obtained a physician order which allowed Resident 44 to have Tylenol and Melatonin at her/his bedside. Staff 2 stated the resident care manager missed the order thus Resident 44 did not receive a self-administration of medication assessment. Staff 2 stated she expected all residents, who desired to self-administer medications, have an assessment completed and be provided with a lockbox prior to having medications at the bedside.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation and interview it was determined the facility failed to provide maintenance to maintain a safe, comfortable and homelike environment for 1 of 1 facility reviewed for physical environment. This placed residents at risk for an unsafe and unkempt interior building. Findings include:</p> <p>1. An observation on 6/2/25 at 9:39 AM, revealed the wall to the right of room [ROOM NUMBER]'s bed was in disrepair with scratches of paint missing from the wall.</p> <p>On 6/5/25 at 2:02 PM, Staff 8 (Maintenance Director) observed the wall to the right of room [ROOM NUMBER]'s bed which was in disrepair with scratches of paint missing from the wall. Staff 8 stated he was unaware of the scratches of paint missing from the wall and he would expect the wall to be painted.</p> <p>On 6/6/25 at 11:25 AM Staff 1 (Administrator) stated she expected all resident rooms to be in good condition and walls maintained.</p> <p>2. On 6/2/25 at 10:35 AM four sections of approximately 5 feet long areas of carpet were observed buckled 4 inches high in a high traffic area of the third floor.</p> <p>On 6/5/25 at 2:04 PM Staff 8 (Maintenance Director) stated the areas of buckled carpet had been present for a significant amount of time and confirmed they were tripping hazards particularly for those with a shuffling gait.</p> <p>3. Resident 355 admitted to the facility on [DATE] with diagnoses including aftercare following cardiovascular surgery.</p> <p>On 6/2/25 at 10:03 AM, Resident 355's window was observed to have a bath towel draped over the opening. Resident 355's room was located on the fifth floor of the facility, and she/he stated the towel was to prevent the draft from coming into the room. Resident 355 stated there was nothing holding the window closed and demonstrated by detaching the window. Resident 355 stated the window was this way since her/his admission to the facility. The window was observed to have no screen.</p> <p>On 6/3/25 at 10:18 AM, Resident 355 stated a gust of wind had blown the window and towel down to the floor and Staff 8 (Maintenance Director) screwed the window shut.</p> <p>On 6/5/25 at 3:40 PM, Staff 8 (Maintenance Director) acknowledged the arms of Resident 355's window had broken off the rivets on 6/3/25. Staff 8 stated the detachable window was a safety issue for residents and anybody who came into the room. Staff 8 stated he did not have a system to check facility windows for safety and repair before residents moved into the facility and there was no system to audit current resident windows for repair and maintenance.</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>Based on observation, interview and record review it was determined the facility failed to ensure a system was in place to receive and resolve resident and/or resident representative grievances for 1 of 1 sampled facility reviewed for Resident Council. This placed residents at risk for unreported and unresolved grievances. Findings include:</p> <p>Record review of the facility's 2025 Grievances binder revealed written grievances were completed by residents or family members on the following dates:</p> <ul style="list-style-type: none"> <li>- 1/20/25;</li> <li>- 3/27/25;</li> <li>- 4/14/25;</li> <li>- 5/24/25;</li> <li>- 5/30/25.</li> </ul> <p>Record review of the facility's 2024 Grievances binder revealed written grievances were completed by residents or family members only four times in 10/2025. No other grievance were completed in 2024.</p> <p>During the 6/4/25 at 1:30 PM Resident Council meeting, multiple residents stated they did not know there was a grievance process in the facility, they did not know how to file a grievance and several stated it did not matter because when you reported a concern to staff nothing was ever done.</p> <p>On 6/4/25 the lobby reception area, facility common areas on the third, fourth and fifth floors were observed. No information was clearly visible regarding how to file a grievance in writing or orally, how to submit a grievance anonymously or readily available grievance forms.</p> <p>On 6/5/25 at 1:22 PM Staff 16 (CMA) stated if a resident expressed a concern, they would tell the charge nurse, Resident Care Manager or DNS. Staff 16 stated they had not provided grievance forms to residents.</p> <p>On 6/5/25 at 1:29 PM Staff 5 (LPN/Charge Nurse) stated if a resident expressed concerns, they would tell the Resident Care Manager and they thought there might be a grievance form.</p> <p>On 6/5/25 at 3:31 PM Staff 15 (CNA) stated if a resident or family expressed a concern, they would tell the Charge Nurse. Staff 15 could not recall assisting a resident or family member with a grievance form.</p> <p>On 6/5/25 at 3:42 PM Staff 14 (Social Services) acknowledged for the past week she had been the facility's Grievance Officer. Staff 14 confirmed the 2024 and 2025 grievance binders were correct and no other grievances were on file. Staff 14 acknowledged the grievance forms were not available to residents or family unless a staff member provided and collected the grievance form.</p> <p>(continued on next page)</p>		

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F 0585  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	On 5/31/24 at 11:01 AM Staff 1 (Administrator) stated the grievance forms were available at nursing stations and residents needed to ask for them. Staff 1 confirmed the residents did not have a means to complete grievance form anonymously. Staff 1 confirmed the lack of grievances filed by residents or resident representatives in 2024 and 2025.		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>Based on interview and record review it was determined the facility failed to complete a comprehensive assessment for 4 of 8 sampled resident (#s 3, 254, 355 and 404) who were reviewed for accidents, ADLs, pain and food. This placed residents at risk for unidentified care needs. Findings include:</p> <ol style="list-style-type: none"> <li>Resident 3 admitted to the facility in 5/2018 with diagnoses including dementia.</li> </ol> <p>Resident 3's Annual MDS completion deadline date was 4/22/25 and was incomplete as of 6/4/25 at 12:49 PM.</p> <p>On 6/5/25 at 4:27 PM, Staff 2 (DNS) confirmed Resident 3's Annual MDS was not completed in the required time frame. Staff 2 stated she expected the MDS assessments to be completed within the required timeframes.</p> <ol style="list-style-type: none"> <li>Resident 254 was readmitted to the facility in 5/2025 with diagnoses including chronic kidney disease and transient ischemic attack (interruption of bloodflow to the brain).</li> </ol> <p>Resident 254's admission MDS completion deadline date was 5/9/25 and was incomplete as of 6/5/25 at 1:32 PM.</p> <p>On 6/5/25 at 1:52 PM Staff 2 (DNS) stated she was responsible for completion of Resident 254's admission MDS. Staff 2 confirmed Resident 254 admission MDS had not been completed within the required 14 days of her/his admission.</p> <ol style="list-style-type: none"> <li>Resident 355 admitted to the facility in 5/2025 with diagnoses including aftercare following cardiovascular surgery.</li> </ol> <p>Resident 355's admission MDS completion deadline date was 6/2/25 and was incomplete as of 6/5/25.</p> <p>On 6/5/25 at 11:59 AM, Staff 10 (RNCM) stated she was the person who was responsible for completing MDS assessments and acknowledged Resident 355's MDS assessment was late. Staff 10 stated the facility struggled with completing MDS assessments timely.</p> <ol style="list-style-type: none"> <li>Resident 404 admitted to the facility in 5/2025 with diagnoses including acute chronic diastolic (congestive) heart failure.</li> </ol> <p>Resident 404's admission MDS completion deadline date was 6/1/25. The admission MDS was signed as complete on 6/2/25 (one day late).</p> <p>On 6/5/25 at 11:59 AM, Staff 10(RNCM)stated she was the person responsible for completing MDS assessments and acknowledged the Resident 404's MDS assessment was late. Staff 10 stated the facility struggled with completing MDS assessments timely.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>Based on record review and interview it was determined the facility failed to complete MDS assessments which reflected accurate mental health diagnoses for 1 of 5 sampled residents (#45) reviewed for medications. This placed residents at risk for inaccurate assessment and care. Findings include:</p> <p>Resident 45 was admitted in 2/2025 with diagnoses including major depressive disorder (mood disorder) and schizophrenia (chronic brain disorder characterized by disconnection from reality).</p> <p>On the 2/7/25 Admissions MDS and the 5/13/25 Quarterly MDS, schizophrenia was coded in Section I.</p> <p>On 6/6/25 at 9:05 AM and at 11: 22 AM, Staff 2 (DNS) stated there was no supporting evidence in the medical record regarding Resident 45's diagnosis of schizophrenia and the MDS should not have been coded without supporting evidence of the diagnosis.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on interview and record review it was determined the facility failed to ensure Staff 17 (Former Agency LPN) adhered to professional standards for medication management and licensed nurse oversight of assigned residents. This placed residents at risk for adverse side effects of medication and unmet medical needs. Findings include:</p> <p>The facility initiated an investigation on 3/1/24 regarding Staff 17 for her night shift which started on 2/29/24. Staff 2 (DNS) completed interviews and record reviews for residents which were assigned under Staff 17's supervision. Staff 2 concluded on the evening of 2/29/24 until 3/1/24 at about 6:30 AM, Staff 17 slept in her car in the facility parking lot most of the shift and was not available. Staff 2 concluded seven residents missed ordered medications, opportunities for PRN medications or treatments.</p> <p>On 6/4/25 at 6:39 AM Staff 18 (CNA) confirmed Staff 17 was the charge nurse when she worked in the facility on 3/1/24. Staff 18 stated Staff 17 went missing from the facility and at around 6:00 AM she found Staff 17 asleep in her car and Staff 17 told her she did not think she could finish the shift. Staff 18 stated Staff 17 was a mess.</p> <p>On 6/4/25 at 7:39 AM Staff 19 (LPN) confirmed she worked the night shift when Staff 17 was scheduled to work on 3/1/24. Staff 19 reported Staff 17 was late to her shift on 2/29/24, left the facility sometime during the shift and by the time Staff 17 was found on 3/1/24 at 6:00 AM the morning medications were scheduled to be passed. Staff 19 stated she instructed Staff 18 to inform Staff 17 she needed to return to the facility to count medications before the end of the shift. However, Staff 17 told Staff 18 she was not going to return to the shift.</p> <p>On 6/5/25 at 10:38 AM the Agency Staffing company provided three phone numbers to contact Staff 17. Attempts were made to call Staff 17 on 6/5/25 at 10:47 AM. Two of the phone numbers were disconnected, one phone number had a generic voicemail message and a voicemail was left for Staff 17 to return the phone call. No return phone call was received by Staff 17.</p> <p>On 6/6/25 at 9:50 AM Staff 2 confirmed the investigation for Staff 17 leaving the facility during the night shift of 2/29/24 to 3/1/24 and seven residents were found to have missed medications, opportunities for medications or treatments. Staff 2 stated she expected all licensed nurses to attend to the residents they were assigned and to complete provider orders for the medications and treatments.</p> <p>Refer to F684</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, interview and record review, it was determined the facility failed to implement fall interventions to reduce hazards and risks for 1 of 3 sampled resident (#3) reviewed for accidents. This placed residents at risk for injury. Findings include:</p> <p>Resident 3 was admitted to the facility in 2018 with diagnoses including dementia and diabetes.</p> <p>Fall/Post Fall Assessments reviewed from 11/16/24 to 6/4/25 revealed Resident 3 experienced a fall on the following dates:</p> <ul style="list-style-type: none"> <li>- 11/16/24;</li> <li>- 11/29/24;</li> <li>- 12/24/24;</li> <li>- 1/4/25;</li> <li>- 2/5/25;</li> <li>- 2/8/25;</li> <li>- 4/23/25;</li> <li>- 5/30/25.</li> </ul> <p>Resident 3's 1/14/25 Quarterly MDS was assessed with a BIMS score of three (severely cognitively impaired) and identified over the past quarter she/he experienced two or more falls with no major injury.</p> <p>Resident 3's 6/4/25 at risk for falls care plan directed staff to implement the following:</p> <ul style="list-style-type: none"> <li>- Make sure the door to the room was opened wide enough so staff could visualize if she/he was attempting to get out of bed;</li> <li>- To keep her/his room door open except when providing care;</li> <li>- Leave wheelchair at bedside at the foot of bed to prevent her/him ambulating on her/his own;</li> <li>- Place her/his cane next to her/his bed, near the head of bed when she/he was in bed and next to her/his wheelchair when she/he was out of bed.</li> </ul> <p>On 6/4/25 at 8:07 AM Resident 3's room door was closed more than halfway and unable to visualize her/him from the hallway.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/4/26 at 8:10 AM and 9:49 AM Resident 3 was observed to in bed resting and her/his wheelchair was across the room under the television.</p> <p>On 6/4/25 at 4:14 PM Resident 3's door was closed to her/his room and she/he was heard to yell a loud moaning sound multiple times. At 4:21 PM a staff member walked past her/his room and did not open the door. The surveyor knocked and opened the door to check on her/his safety. Resident 3 was observed sitting in her/his wheelchair with no pants on and pointed to the bathroom.</p> <p>On 6/5/25 at 3:41 PM Resident 3 was observed resting in bed and her/his cane was placed next to the bathroom wall and the resident's wheelchair was across the room under the television.</p> <p>On 6/5/25 at 3:45 PM Staff 15 (CNA) confirmed Resident 3's cane was at the bathroom wall and the wheelchair was across the room. Staff 15 stated she obtained her information to care for residents from the care plan and the cane and wheelchair should be near Resident 3's bed while she/he was in the bed.</p> <p>On 6/5/25 at 4:07 PM Staff 21 (LPN) confirmed Resident 3's cane and wheelchair were expected to be near her/his bed at the time for fall prevention.</p> <p>On 6/5/25 at 4:12 PM Staff 2 (DNS) confirmed Resident 3's care planned fall interventions were not in place in her/his room. Staff 2 stated she expected staff to implement and follow the care plan interventions.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  385141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/06/2025
NAME OF PROVIDER OR SUPPLIER  Mt. Tabor Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  6040 SE Belmont Street Portland, OR 97215	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview and record review it was determined the facility failed to properly store food and failed to maintain sanitary conditions in 1 of 1 kitchen and 1 of 3 unit refrigerators. This placed residents at risk for food borne illness and contaminated food. Findings include:</p> <p>1. On 6/2/25 at 8:12 AM during the initial tour of kitchen, the following items were observed in refrigerator walk-in #1:</p> <ul style="list-style-type: none"> <li>*Tofu salad dated 5/26/25 (stored eight days)</li> <li>*Chicken salad dated 5/26/25 (stored eight days)</li> <li>*Two separate containers of lunch meat which were undated.</li> </ul> <p>On 6/2/25 at 10:36 AM Staff 11 (Dietary Manager) confirmed salad was made on 5/26/25 and she discarded the items after four days. The salad should have been removed from the refrigerator.</p> <p>2. A review of the undated Employee Cleanliness Policy for the kitchen revealed facial hair must be completely covered with a beard net.</p> <p>On 6/2/25 at 8:23 AM Staff 12 (Dietary Aid) was observed with a beard which was uncovered while moving throughout the kitchen prepping items for breakfast.</p> <p>On 06/2/25 at 10:39 AM Staff 8 (Maintenance Director) was observed with a beard and entered the kitchen area without obtaining a beard net.</p> <p>On 6/2/25 at 10:39 AM Staff 11 (Dietary Manager) confirmed staff were required to wear facial beard restraints and hairnets whenever in the kitchen area.</p> <p>3. An undated Refrigerator Maintenance and Food Storage Policy stated all refrigerators located in unit kitchenettes were to be maintained in a clean, sanitary and operational condition. Cleaning and Maintenance, Housekeeping was responsible to clean and sanitize the refrigerator interior and exterior weekly. It was expected that staff would immediately clean any spills or removed spoiled foods in between cleanings.</p> <p>On 6/3/25 at 1:49 PM a review of the fourth floor unit refrigerator revealed a spilled substance and crumbs on the bottom of the fridge. The following items were undated and unlabeled:</p> <ul style="list-style-type: none"> <li>*Foiled item in a plastic bag stuck to the bottom of the refrigerator.</li> <li>*Glass container with food unlabeled without a date.</li> </ul> <p>On 6/3/25 3:03 PM Staff 4 (CMA) and Staff 13(CNA) were present for an interview. Staff 4 stated staff were responsible for monitoring and discarding food items after three days however she was unsure who was responsible for cleaning the refrigerator. Staff 13 acknowledged food items in the refrigerator were unlabeled.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  385141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/06/2025
NAME OF PROVIDER OR SUPPLIER  Mt. Tabor Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  6040 SE Belmont Street Portland, OR 97215	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/4/25 at 8:40 AM Staff 8 (Maintenance Director) stated they believed Staff 11 (Dietary Manager) was in charge of the unit refrigerators.</p> <p>On 6/3/25 at 11:19 AM and 6/4/25 at 9:08 AM Staff 11 stated staff were expected to discard any items in the unit refrigerators which were undated or if the date on the food item exceeded three days. Staff 11 stated housekeeping was responsible for cleaning the unit refrigerators.</p> <p>4. On 6/3/25 at 12:17 PM, 6/4/25 at 9:04 AM, and 6/5/25 at 10:13 AM a fan was observed blowing on a shelving unit with cleaned utensils and dishware. The fan was covered with dark brown debris over the intake vent.</p> <p>On 6/5/25 at 1:43 PM Staff 11 (Dietary Manager) acknowledged the dirty fan in the dishwashing area and confirmed it was not to be placed in the dishwashing area.</p>		